

Chapter 5

Empirical Evidence for Transference-Focused Psychotherapy and Other Psychodynamic Psychotherapy for Borderline Personality Disorder

Kenneth N. Levy, Rachel H. Wasserman, Lori N. Scott, and Frank E. Yeomans

Psychodynamic Psychotherapy for Borderline Personality Disorder

Writing about psychodynamic psychotherapy for borderline personality disorder (BPD) is difficult because it is not a unified approach. In fact, it is often said that psychoanalysis, although frequently used singularly, is in actuality a plural noun representing an array of theoretical ideas and technical applications. These schools broadly include ego psychology, object relations theory, self-psychology, and attachment theory.

These psychodynamic models can be contrasted with and complemented by other models for treating BPD, such as the behavioral [1], cognitive [2–4], interpersonal [5], and integrative (e.g., dialectical behavior therapy, DBT) [6]. What distinguishes a psychodynamic approach is an explicit focus on both the conscious and unconscious aspects of mental functioning and the implications of these experiences in interaction with biological forces and interpersonal influences.

It is generally concluded that those trained psychoanalytically or dynamically are not interested in research for a host of reasons ranging from the challenges of designing a randomized controlled trial (RCT) that would demonstrate the efficacy of a psychoanalytic approach to epistemological and philosophical disagreements about the nature of science (see [7–9] debates for an illustration). Although many in the psychoanalytic community in the past have been cautious regarding the value of research, some of the earliest psychotherapy research was performed by psychoanalysts [10–18]. Additionally, psychoanalyst and psychodynamic clinicians are increasingly becoming interested in testing psychodynamic hypotheses and establishing a stronger evidence base for treatments based on psychodynamic ideas [8, 9, 19–25]. This increased interest in psychotherapy outcome research has been particularly fruitful with regard to

K.N. Levy

Department of Psychology, Pennsylvania State University, 521 Moore Bldg., University Park, PA 16802, USA
e-mail: klevy@psu.edu

the study of BPD. Severe personality disorders such as BPD are increasingly seen as the mainstay of psychoanalytic clinical work.

A number of these psychodynamic treatments may be quite effective in treating patients with BPD; however, for the purpose of this chapter, we focus primarily on Otto Kernberg's [26, 27] transference-focused psychotherapy (TFP). Before examining the empirical evidence for the efficacy and effectiveness of TFP, we will chronicle findings from the Menninger Foundation Psychotherapy Research Project (MFPRP) and review the evidence for the effectiveness of Russell Meares's [28] interpersonal psychodynamic psychotherapy and Peter Fonagy and Anthony Bateman's [29] mentalization-based therapy (MBT). We will begin by framing the issues in conceptualizing empirical evidence in psychotherapy studies and we will finish with a summary of conclusions that can be drawn from the literature.

What Constitutes Empirical Evidence?

Although RCTs are generally considered the gold standard and have important methodological strengths [30], they also suffer from a number of important limitations [24, 30–34]. The focus on RCTs has had the unintended consequence of overlooking other evidence that is relevant for assessing the empirical support of treatments. The numerous limitations of efficacy studies have led many investigators to recommend searching for empirically supported principles (ESPs) of treatment, or evidence-based explanations of treatment, rather than credentialed, trademarked, brand-name, or evidence-based treatment packages [31, 35–37].

Gabbard and colleagues [38] and others [34, 39] have discussed a stage model, or hierarchy, of treatment evidence as a function of considering both internal and external validity. They have suggested that evidence from multiple sources within this model is necessary in order to build an empirically grounded framework for specific forms of psychotherapy. In ascending levels of internal validity and descending levels of external validity, the hierarchy of treatment evidence starts with the provision of an argument or the articulation of clinical innovation and proceeds through clinical case studies, clinical case series, pre-post designs without comparison groups, quasi-experimental designs that include comparisons but without randomization, and then RCTs. Within the RCT category, there is a hierarchy with regard to the control group employed ranging from the use of wait-list controls through treatment as usual groups, placebos, and finally comparison with established, well-delivered alternative treatments. Levy and Scott [34] suggested that this hierarchy, in combination with the examination of evidence for specific techniques and mechanisms of action [40, 41], provides better breadth of evidence and better validity than focusing on RCTs alone. Others have noted that naturalistic studies may be necessary to help bridge the gap between practice and research [42, 43]. Limiting

research, practice, and training exclusively to treatments that have been validated in RCTs could impede reasonable avenues of study in the treatment of BPD and obstruct access to treatments that might be better suited to specific patient subgroups.

Evolving Early Psychodynamic Psychotherapy Research on Borderline Personality Disorder

One of the first systematic attempts at studying psychotherapy outcome of severely disturbed patients was the MFPRP, initially directed by Robert Wallerstein and completed under the stewardship of Otto Kernberg. The Menninger Study [44, 45] began in 1954 and follow-up assessments spanned almost 30 years. In this study, 42 patients were treated, half in classical psychoanalysis and half in supportive and expressive psychodynamic psychotherapies. They were assessed at baseline termination and had multiple follow-ups (100% were followed-up at 2–3 years post-termination). Using detailed case histories from all 42 patients, Wallerstein concluded that supportive techniques “infiltrated” all therapies, including psychoanalysis, and that these techniques accounted for more of the outcome than initially anticipated. This finding has led to the integration of supportive and expressive techniques seen in many psychodynamic psychotherapies [46–48]. Based on separate analyses of the data from the MRPRP, Kernberg [45] concluded that patients with borderline personality treated by skilled therapists who focused their interventions on the transference showed a significantly better outcome than those treated with a more supportive approach. Although Wallerstein and Kernberg’s conclusions appear at odds, they are not mutually exclusive. Supportive techniques could have been used in all treatments to varying degrees, but in Kernberg’s, interpretations were less related to outcome with the subset of patients with BPD. Nevertheless, because these conclusions did not come from an RCT, many skeptics remained unconvinced on both sides.

The MFPRP was a landmark study; however, it is also difficult to interpret not only because patients were not randomized to treatment conditions but also because of uncertainty regarding patient diagnoses.¹ Nevertheless, there are some clear lessons and conclusions that can still be drawn from the MFPRP: (1) classical psychoanalysis is most likely not that helpful for BPD patients (particularly the more severely disturbed borderline patient or what Kernberg calls the low-level borderline patient); (2) to the extent that the psychodynamic psychotherapy was supportive, supportive psychotherapy (SPT) appears less effective for low-level BPD patients; (3) one size does not have to fit

¹ Although, many of the patients referred after multiple treatment failures and it appears that these patients could be classified as BPD, diagnoses were not made using criteria consistent with a contemporary nosological framework.

all – psychoanalysis can be modified to patients' pathology. This last point is particularly important given that clinical techniques should be tied to the specific developmental psychopathology being addressed (see [49] for elaboration of this point).

Contemporary Psychotherapy Research on Borderline Personality Disorder

One hypothesis that was confirmed in the MFPRP is that long-term psychodynamic psychotherapy research is difficult to perform. Many in the field believed that such research was so difficult as to render it unfeasible. However, in 1991, Marsha Linehan published the results of her year-long RCT for BPD in which she examined an integrative cognitive-behavioral therapy (CBT) treatment called DBT as compared to treatment as usual. This seminal study has been highly influential on current training and treatment trends. However, one of the most important aspects of this study was that it showed that RCTs of a long-term treatment could be accomplished and thus stimulated a revival in the rigorous study of long-term psychodynamic treatments for BPD.

Interpersonal Self-Psychological Approach

Russell Meares developed an interpersonal self-psychological (IP) approach for the treatment of BPD guided by the conversational model of Hobson [50], the main aim of which is to foster the emergence of reflective consciousness that William James called *self-consciousness* [51]. A basic tenet of this approach is that self-consciousness is achieved through a particular form of conversation and reflects a specific kind of relatedness. The nearest North American equivalent to this approach comes from Kohut [52] and his followers [53]. Shortly after Linehan published the results of her initial RCT, Meares and colleagues [28] published the results of a pre-post-study examining this approach for patients with BPD. They found that patients at the end of treatment showed an increase in time employed and a decrease in number of medical visits, number of self-harm episodes, and number and length of hospitalizations. Although the inferences that can be drawn from this study are limited by the lack of a control group, these findings supported development and study of psychodynamic treatments for BPD. In a later study [54], researchers compared BPD patients treated twice weekly for 1 year with those in a treatment-as-usual wait-list control group (all wait-listed patients received their usual treatments, which consisted of SPT, crisis intervention only, cognitive therapy, and pharmacotherapy). Thirty percent of IP-treated patients no longer met criteria for a *DSM-III* [55] BPD diagnosis at the end of the treatment year, whereas all of the treatment as usual (TAU) patients still met criteria for the diagnosis. These results demonstrated that psychotherapy based on psychodynamic principles is

generally beneficial to patients with BPD in a naturalistic setting, having strong ecological validity. A follow-up of all patients in this cohort 5 years after the treatment found maintained improvements [56]. At the 5-year follow-up, 40% of the patients no longer met criteria for BPD. In addition, there was a progressive reduction in time spent in hospital (although no decrease in hospitalizations) and an increase in time employed. A recently completed second study of similar design [57] replicated these findings. Clearly the findings from these studies suggest the value of their approach and call for the more stringent testing of an RCT.

Mentalization-Based Therapy

Bateman and Fonagy [58] developed MBT based on the developmental theory of mentalization, which integrates philosophy (theory of mind), ego psychology, Kleinian theory, and attachment theory. Fonagy and Bateman [58] posit that the mechanism of change in all effective treatments for BPD involves the capacity for mentalization – the capacity to think about mental states in oneself and in others in terms of wishes, desires, and intentions. This involves both implicit, unconscious mental processes that are activated along with the attachment system in affectively charged interpersonal situations and coherent integrated representations of mental states of self and others. The concept of mentalization has been operationalized in the reflective function (RF) scale (Fonagy, P., Target, M., Steele, H., & Steele, M. (1998). *Reflective Functioning Manual: Version 5.0, for Application to Adult Attachment Interviews*. Unpublished Manuscript).

In a randomized clinical trial, Bateman and Fonagy [29] compared the effectiveness of 18 months of a psychoanalytically oriented day hospitalization program to routine general psychiatric care for patients with BPD. Patients randomly assigned to the psychoanalytic day hospital program, now called MBT [59], showed statistically significant improvement in depressive symptoms and better social and interpersonal functioning, as well as significant decreases in suicidal and parasuicidal behavior and number of days in inpatient treatment.

Patients were reassessed every 3 months for up to 18 months postdischarge [60]. Follow-up results indicate that patients who completed the MBT not only maintained their substantial gains but also showed continued steady and statistically significant improvement on most measures, suggesting that BPD patients can continue to demonstrate gains in functioning long after treatment has ended. At 18-month postdischarge follow-up, 59.1% of patients treated with MBT were below the BPD diagnostic threshold, compared to only 12.5% of those treated in routine general psychiatric care. This finding is particularly important because while the overall results of Linehan's studies of DBT are suggestive of its value, naturalistic follow-up of patients in DBT shows variable

maintenance of treatment effects, and ongoing impairment in functioning in patients who initially experienced symptom relief. For example, Linehan [61] found no between-group differences in the number of days hospitalized at a 6-month follow-up or in self-destructive acts at the end of a 1-year follow-up (despite the fact that the patients in the DBT group were still receiving DBT therapy, whereas about half the TAU group were not in any therapy). Thus, the durability of the initial gains is unclear; whereas for MBT, there not only is continued improvement, but also seems to be a sleeper effect with increased improvement over time.

An 8-year follow-up of MBT has recently been completed, and the results of that study should be available soon. At this point, the most important tests remaining for MBT are to examine its putative mechanisms of change. Bateman and Fonagy hypothesize that changes in RF underlie the improvements seen in MBT; however, to date findings have not been published regarding changes in levels of RF in MBT-treated BPD patients.

Transference-Focused Psychotherapy

Since the early 1980s, the Borderline Psychotherapy Research Project at New York Presbyterian Hospital-Weill Cornell Medical Center, headed by Drs. John Clarkin and Otto Kernberg, has been systematizing and investigating an object relations treatment of patients with BPD. This group has generated treatment manuals [26, 27, 62] that describe key strategies and techniques of a highly structured, modified dynamic treatment of patients with borderline personality organization called TFP.

Central to TFP are mental representations derived through the internalization of attachment relationships with caregivers. The degree of differentiation and integration of these representations of self and other, along with their affective valence, constitutes personality organization [63]. According to Kernberg, borderline personality can be thought of as severely disturbed level of personality organization, characterized by unintegrated and undifferentiated representations of self and other (what Kernberg calls identity diffusion and manifested in inconsistent view of self and others), the use of immature defenses (e.g., splitting, projective identification, and omnipotent control), and variable reality testing (e.g., poor conception of one's own social stimulus value).

The major goals of TFP are to reduce suicidality and self-injurious behaviors, and to facilitate better behavioral control, increased affect regulation, more gratifying relationships, and the ability to pursue life goals. This is believed to be accomplished through the development of integrated representations of self and others, the modification of primitive defensive operations, and the resolution of identity diffusion that perpetuate the fragmentation of the patient's internal representational world. In this treatment, the analysis of the transference is the primary vehicle for the transformation of primitive

(e.g., split, polarized) to advanced (e.g., complex, differentiated and integrated) object relations. Thus, in contrast to therapies that focus on the short-term treatment of symptoms, TFP has the ambitious goal of not just changing symptoms, but changing the personality organization, which is the context of the symptoms. In contrast to most manuals for CBT or short-term treatments, the TFP manual could be described as principle-based rather than sequentially based, which requires the clinician to be flexible and use clinical judgment. Using video-taped sessions and supervisor ratings, Kernberg and his colleagues have been able to train both senior clinicians and junior trainees at multiple sites to adherence and competence in applying the principles of TFP.

Transference-focused psychotherapy begins with explicit contract setting that clarifies the conditions of therapy, the method of treatment, and the respective roles of patient and therapist. The primary focus of TFP is on the dominant affect-laden themes that emerge in the relationship between borderline patients and their therapists in the here-and-now of the transference. During the first year of treatment, TFP focuses on a hierarchy of goals: containing suicidal and self-destructive behaviors, addressing ways the patient might undermine the treatment since it challenges the patient's fragile and dysfunctional homeostasis, and identifying and recapitulating dominant object relational patterns, as they are experienced and expressed in the here-and-now of the transference relationship.

Within psychoanalysis, TFP is closest to the Kleinian school [64], which also emphasizes a focus on the analysis of the transference. However, TFP can be distinguished from Kleinian psychoanalysis in that TFP is practiced twice per week and that TFP includes a more highly structured treatment frame by emphasizing the treatment contract and a preestablished set of priorities to focus (e.g., suicidality and treatment-interfering behaviors). The role of both the treatment contract and the treatment priorities go beyond that found in more typical psychoanalytic psychotherapy or psychoanalysis, including Kleinian psychoanalysis. In addition, transference interpretations are consistently linked with both extratransference material and, importantly, long-term treatment goals (e.g., better behavioral control). In contrast to Kleinian approaches, the TFP approach is a highly engaged, more talkative, and an interactive one. Additionally, technical neutrality is modified to the extent required to maintain structure. Transference-focused psychotherapy also differs from other expressive psychodynamic approaches with a persistent focus on the here-and-now, a focus on the immediate interpretation of the negative transference, and the emphasis on interpretation of the defensive function of idealization, as well as a focus on the patients' aggression and hostility.

Some of the more salient differences between TFP and DBT, a cognitive-behavioral therapy developed to treat parasuicidal borderline patients, concern parameter of the treatment frame. For example, to avoid the secondary gain that can be experienced by extra contact with the therapist and to encourage the development of autonomy [65], the TFP therapist is considered unavailable between sessions except in the case of emergencies, whereas in DBT, the patient

is encouraged to phone the individual therapist between sessions. Another difference is the emphasis in TFP on technical neutrality versus strategies used in DBT including validation, coaching, and cheerleading. Despite these differences, both TFP and DBT have in common a firm, explicit contract, a focus on a hierarchy of acting out behaviors, a highly engaged therapeutic relationship, a structured disciplined approach, and utilize supervision groups as essential for therapists.

In TFP, hypothesized mechanisms of change derive from Kernberg's [63] developmentally based theory of BPD, which conceptualizes the disorder in terms of unintegrated and undifferentiated affects and representations (or concepts) of self and other. Partial representations of self and other are paired and linked by an affect in mental units called "object relation dyads." These dyads are representational elements of psychological structure. In BPD, the lack of integration of the internal object relations dyads corresponds to a "split" psychological structure in which totally negative dyads are split off or segregated from idealized positive dyads of self and other. The putative global mechanism of change in patients treated with TFP is the integration of these polarized affect states and representations of self and other into a more coherent whole. Through the exploration and integration of these "split-off" cognitive-affective units of self- and other representations, Kernberg postulates that the patient's awareness and experience in life become more enriched and modulated, and the patient develops the capacity to think more flexibly, realistically, and benevolently. The integration of the split and polarized concepts of self and others leads to a more complex, differentiated, and realistic sense of self and others that allows for better modulation of affects and in turn clearer thinking. Therefore, as split-off representations become integrated, patients tend to experience an increased coherence of identity, relationships that are balanced and not at risk of being overwhelmed by aggressive affect, a greater capacity for intimacy, a reduction in self-destructive behaviors, and general improvement in functioning.

Using the triad of clarifications, confrontations, and interpretations, the TFP therapist provides the patient with the opportunity to integrate cognitions and affects that were previously split and disorganized. In addition, the engaged, interactive, and emotionally intense stance of the therapist is typically experienced by patients as emotionally holding (containing) because the therapist conveys that he or she can tolerate the patient's negative affective states. The therapist's expectation of the patient's ability to have a thoughtful and disciplined approach to emotional states (i.e., that the patient is a fledgling version of a capable, responsible, and reflective adult) is thought to be experienced as cognitively holding. The therapist's timely, clear, and tactful interpretations of the dominant, affect-laden themes and patient enactments in the here and now of the transference frequently shed light on the reasons that representations remain split off and thus facilitate integrating polarized representations of self and others.

With regard to the flow of treatment, the structured frame of TFP facilitates the full activation of the patient's distorted internal representations of self and other in the ongoing relationship between patient and therapist; this constitutes the transference. It is expected that the unintegrated representations of self and other will be activated in the treatment setting as they are in every aspect of the patient's life. These partial representations are constantly active in determining the patient's experience of real-life interactions and in motivating the patient's behavior. The difference in the therapy is that the therapist both experiences the patient's representation of the interaction and also nonjudgmentally observes and comments on it (within the psychoanalytic literature, this is known as the "third position"). This is facilitated by the therapist establishing a treatment frame and contract, which in addition to providing structure and holding for the patient and a consensual reality from which to examine acting out behavior. The therapist does not respond to the patient's fragmented partial representation, but helps the patient observe it, as well as the implied other that is paired with it. Such interventions are facilitated by the therapist's having already established a consistent treatment frame and contract. In addition to providing structure and a consensual reality from which to examine a patient's acting out behaviour, the treatment frame and contract assists the therapist in minimizing his or own potential for unconstructive, non-therapeutic interactions.

As these internal object relations unfold in the relation with the therapist, the TFP therapist seeks to explicate the patient's internal experience through clarification and reflection because the patient may not have a clear representation of his or her own experience. However, in most cases, this technique alone will not lead to integration, because clarification alone does not address the conflicts that keep the partial representations separated. Confrontation – the technique of enquiring about the elements of the patient's verbal and nonverbal communications in contradiction to each other – and interpretation of obstacles to integration are needed to get the patient beyond the level of split organization. Interpretation includes helping the patient see that he or she identifies at different moments in time with each pole of the predominant object relation dyads within him or her. Increasing the patient's awareness of his or her range of identifications increases his or her ability to integrate the different parts.

On the practical level, the relationship with the therapist in TFP is structured under controlled conditions in order to allow the patient to experience affects without overwhelming the situation and destroying communication. The negotiation of a treatment frame provides a safe setting for the reactivation of the internalized relation paradigms. The safety and stability of the therapeutic environment permits the patient to begin to reflect about what is going on in the present with another person, in light of these internalized paradigms. Similar to what attachment theorists would describe as a safe haven, which along with the guidance of an attachment figure, allows for the exploration of the content of the mind. With guidance from the therapist, the patient becomes aware of the extent to which his perceptions are based more on internalized representations than on what is realistically going on now. The therapist's help

to cognitively structure what at first seemed chaotic also provides a containing function for the patient's affects.

Transference-focused psychotherapy fosters change by inhibiting the vicious circle of setting off reactions in others that often occur when the patient behaves with emotion dysregulation in the "real" world (often eliciting the very responses that the patient fears from others). The objective and nonjudgmental attitude of the therapist assists in the reactivation of the internalized experience patterns, their containment, and their exploration for new understandings. Instead of attempting to deter these behaviors by educative means, TFP brings the patient's attention to the internal mental representations behind them, with the goal of understanding, modifying, and integrating them.

Key to the change process is the development of introspection or self-reflection; the patient's increase in reflection is hypothesized to be an essential mechanism of change. The disorganization of the patient involves not only internal representations of self and others, relationships with self and others, and predominance of primitive affects, but also the processes that prevent reflection and full awareness. These primitive defensive processes that characterize a split psychological structure erase and distort awareness. Thought processes can be so powerfully distorted that affects, particularly the most negative ones, are expressed in action without cognitive awareness of their existence.

As the patient progresses in the course of TFP from split-off contradictory self-states to reflectiveness and integration, from action to reflection, this increase in reflectiveness involves two specific levels. The first level is an articulation and reflection of what one feels in the moment. The patient increases his or her ability to experience, articulate, and contain an affect and to contextualize it in the moment. A second, more advanced, level of reflection is the ability to place the understanding of momentary affect states of self and others into a general context of a relationship between self and others across time. This level reflects the establishment of an integrated sense of self and others – a sense against which momentary perceptions can be compared and put in perspective.

One of the important tactics in TFP is setting up the treatment contracts, before beginning the therapy *per se*. The function of the contract is to define the responsibilities of patient and therapist, protecting the therapist's ability to think clearly and reflect, provide a safe place for the patient's dynamics to unfold, set the stage for interpreting the meaning of deviations from the contract as they occur later in therapy, and provide an organizing therapeutic frame that permits therapy to become an anchor in the patient's life. The contract specifies the patient responsibilities, such as attendance and participation, paying fee, and reporting thoughts and feelings without censoring. The contract also specifies the therapists' responsibilities, including attending to the schedule, making every effort to understand and, when useful, comment, clarifying the limits of his/her involvement, and predicting threats to the treatment. Essentially, the treatment contract makes the expectations of the therapy explicit [66]. There is some controversy regarding the value of treatment

contracting. The APA guidelines recommend that therapist contract around issues of safety. Others [67] have suggested that the evidence contraindicates their use and shows them to be ineffective [68]. However, the Kroll [68] study was designed to determine the extent that no-suicide contracts were employed (which was found to be 57%), and although 42% of psychiatrists who used no-suicide contracts had patients who either committed suicide or made a serious attempt, the design of the study does not allow for the assessment of the efficacy of no-suicide contracts. Other data suggest the utility to contracting around self-destructive behavior and treatment threats [69–73]. For example, Yeomans and colleagues [69] in a pre–post study of 36 patients with BPD found that the quality of the therapist’s presentation and handling of the patient’s response to the treatment contract correlated with treatment alliance and the length of treatment. In addition, in our earlier work on TFP [70], when we did not stress treatment contracting, our drop-out rates were high (31 and 36% at 3 month and 6 month marks of treatment). However, based on the findings of Yeomans et al. [69], Kernberg and colleagues further systematized and stressed the importance of the treatment contract, and in later studies [71, 73, 74], our group found lower rates of dropout (19, 13, and 25%) over a year-long period of treatment. We suggest that these findings taken together suggest that sensitively but explicitly negotiated treatment contracts may have one of the desired effects: resulting in less dropout and longer treatments. Future research will need to address the issue of treatment contracts more directly, particularly testing the effects on parasuicidity and suicidality.

Transference-Focused Psychotherapy Case Study

As an example of a TFP treatment contract, we offer the case of a 35-year-old woman, who was referred for TFP after 10 years of multiple outpatient and inpatient treatments for depression. After careful assessment, her diagnosis disorder was determined to be borderline PD with strong narcissistic features. The contracting phase of treatment involves the therapist’s describing a set of preconditions for treatment that are directly tied to the patient’s presenting difficulties. The first stage of the contracting process was to discuss with the patient that her depressive moods might stem from underlying ways of thinking of herself and others that were automatic to her, not fully in her awareness and not fully accurate. The patient was interested in exploring this possibility. Discussion of the contract followed this discussion of the diagnosis. The therapist explained that an exploratory treatment could not provide true gains unless the patient was involved in some kind of activity in life. The patient took the position that any kind of activity was so overwhelming to her that it threw her back into the depths of depression. The therapist pointed out that the patient was not presently exhibiting the symptoms of a depressive episode. The patient replied that this was because of her extensive treatment and that she had

achieved a fragile equilibrium that would be shattered by any attempt to increase her level of functioning. The therapist was sure enough of the diagnosis of a primary Axis II disorder, and his consequent belief that the patient was capable of taking some responsibility in the area of functioning, to state: "The choice of treatment is entirely up to you. If you find what I'm saying is unreasonable, or simply not something that would interest you, we could look into alternative more supportive treatments that would not ask as much of you, but would likely not lead to as much change. I understand that entering into situations where you are involved with other people is very stressful for you and that you have failed at multiple efforts to function in the past. What I am proposing is that you begin some kind of activity, and when you begin to have those reactions, we can explore here what is going on there that contributes to your anxiety and distress. It will very likely be related to the kind of reactions you have that we will be exploring here and in other settings."

The patient agreed in principle. Then the contracting had to address what activity the patient might realistically engage in at that point. She initially proposed reading stories to children at the local library one afternoon each week. The therapist felt that this did not adequately address the needs of an intelligent adult woman to have some income. He proposed starting with a part-time clerical position while she looked into various training possibilities. The patient responded: "I'd rather die than work at a clerical job." This reaction supported the therapist's diagnostic impression. Their discussion, over two sessions, led to the patient's proposing that she could begin to get training in a paraprofessional area, which she did.

Once the treatment frame is in place, the therapy begins and the central work involves helping the patient recognize and integrate the various split-off representations of self and other that make up the patient's internal world. An example is that of a woman who started TFP at age 32 with problems of depression, chronic suicidal ideation, and an inability to maintain social relations or any job because of chronic arguments with others. The first prominent dyad that emerged in her discourse was the image of a weak, injured self who was constantly berated and put down by others. Yet, the patient's initial interactions with the therapist were characterized by a nonstop discourse on her part that left the therapist feeling controlled and unable to speak freely. Exploration of this revealed a devalued image of self in relation to another who would berate her and eventually abandon her. The patient's primitive defense mechanisms were such that she projected the "bad" critical and abandoning object on the therapist and then felt the need to then control it in him. The following interpretation freed the patient from her use of projective identification to participate in a more open and interactive interchange and to explore further.

Responding to the patient's rapid-fire speech in every session, the therapist commented: "Have you noticed how you fill the sessions with a kind of pressured speech that does not leave me any room to comment? (generally, if the

therapist tried to speak, the patient would speak over him.) It is as though you feel the need to control me, to keep me from acting freely.”

Patient [angrily] “If I didn’t control you, you’d leave me, like everyone else.”

Exploration of this fear helped the patient understand that her behavior was rooted in an anxiety stemming from an internal image of the other that determined how she experienced her therapist. The next stage of therapy was marked by the patient’s increasing criticism of the therapist, which she did not recognize as such consciously. She felt she was reacting in a justified way to his shortcomings and failures toward her (e.g., his going away at times). The therapist helped the patient observe her own identification with and enacting of the devaluing, critical one, helped her see its relation to feeling devalued and criticized, and also helped her understand that neither one of these needed to be the case. The patient gained awareness that the drama she experienced endlessly with others was the enactment of a relationship between two parts of herself and that she was living the contradiction of being both the victim and the critic/attacker, although with less awareness of the latter and usually experiencing this relationship as between her and others (a situation she often created) rather than within herself. This awareness allowed her to begin to tame the harsh critical part within her.

As the therapy advanced, there were signs of the patient’s attachment to the therapist’s attachment to the therapist: coming on time while protesting that therapy was a waste of time, missing her therapy while angrily proclaiming that her therapist was irresponsible for going away, etc. Her therapist made the interpretation that it must be difficult for her to be attached to him (thus going a step beyond anything she had stated and bringing the positive dyad into their dialogue more explicitly) because of her fear that the kind of longing she experienced for him could never be reciprocated by anyone. The therapist’s matter-of-fact mention of this imagined positive relationship freed the patient to begin to discuss her fantasies of an ideal relationship with him as the perfect provider and protector she had never experienced. The patient had been reluctant to express this idealized view of their relation for fear that the negative, rejecting image of the other would prove real and destroy her longing for closeness in a brutally humiliating way. The ability to discuss and observe both sides of the split allowed the patient to achieve an integrated, more balanced view of herself, others, and relationships.

Empirical Evidence for Transference-Focused Psychotherapy

There is now accumulating evidence for the effectiveness and efficacy of TFP [71, 75, 76]. The initial study [71] examined the effectiveness of TFP in a pre–post design. Participants were recruited from varied treatment settings (i.e., inpatient, day hospital, and outpatient clinics) within the New York metropolitan area.

Participants were all women between the ages of 18 and 50 who met criteria for BPD through structured interviews. All therapists (senior therapists to postdoctoral trainees) selected for this phase of the study were judged by independent supervisory ratings to be both competent and adherent to the TFP manual. Three senior supervisors rated the therapists for TFP adherence and competence. “Findings regarding adherence and competence. After the completion of all treatment in the study, three senior supervisors rank-ordered the therapists for adherence and competence in TFP. The range was purposefully truncated, as all therapists were consistently supervised to adherence during the treatment period. With this limited range of competence, we found no relationship between the rank order and patient outcome.” Throughout the study, all therapists were supervised on a weekly basis by Kernberg and at least one other senior clinician.

Overall, the major finding in this pre–post study was that patients with BPD who were treated with TFP showed marked reductions in the severity of parasuicidal behaviors, fewer emergency room visits, hospitalizations, days hospitalized, and reliable increases in global functioning. The effect sizes were large and no less than those demonstrated for other BPD treatments [29, 77]. The one-year drop-out rate was 19.1% and no patient committed suicide. These results compared well with other treatments for BPD: Linehan et al.’s study [77] had 16.7% drop out and one suicide (4%); Stevenson and Meares’ study [28] had a 16% drop-out rate and no suicides; and Bateman and Fonagy’s study [29] had 21% drop-out rate and no suicides. None of the treatment completers deteriorated or was adversely affected by the treatment. Therefore, it appears that TFP is well-tolerated. Further, 53% of participants no longer met criteria for BPD after 1 year of twice-weekly outpatient treatment [78]. This rate compared quite well with that found by others [28, 60]. In addition, reliable increases in global functioning and a generally low drop-out rate were observed in these patients. These results suggest the potential utility of TFP for treating BPD patients and that more research on TFP is warranted (Table 5.1).

A second study [72] provided further support for the effectiveness of TFP in treating BPD. In this study, 26 women diagnosed with BPD and treated with TFP were compared to 17 patients in a TAU group. There were no significant pretreatment differences between the treatment group and the comparison group in terms of demographic or diagnostic variables, severity of BPD symptomatology, baseline emergency room visits, hospitalizations, days hospitalized, or global functioning scores. The 1-year attrition rate was 19%. Patients treated with TFP, compared to those treated with TAU, showed significant decreases in suicide attempts, hospitalizations, and number of days hospitalized, as well as reliable increases in global functioning. All of the within-subjects and between-subject effect sizes for the TFP-treated participants indicated favorable change. The within-subject effect sizes ranged from 0.73 to 3.06 for the TFP-treated participants, with an average effect size of 1.19 (which is well above what is considered “large” [79]) (Table 5.2).

The only RCT to date that has compared an experimental treatment for BPD to an established alternative treatment has been the RCT conducted by The

Table 5.1 Results of Clarkin et al.’s [71] TFP pre–post study (*N* = 17)

	Means		<i>p-value</i>
	Pre-Tx	Post-Tx	
BPD Dx	100%	47.10%	–
Parasuicidal behavior	5.18	4.24	0.45
Medical risk	1.72	1.14	0.02
Physical condition	1.89	1.12	0.01
Hospitalizations	1.24	0.35	0.02
Days hospitalized	39.21	4.53	0.06
GAF	45.57	59.85	<0.001

BPD Dx was assessed as the percentage of patients with a DSM-III diagnosis of BPD, from the SCID-II. Parasuicidal behavior, medical risk, and physical condition were all assessed from the suicidality subscale of the Overt Aggression Scale – Modified Version for Outpatients [109] over the previous 12-month period. Medical risk was indicative of the severity of parasuicidal and suicidal behaviors. Physical condition was indicative of the condition following such behaviors. Hospitalizations were assessed by checking medical records and represent the total number of hospitalization in the previous 12-month period. Global Assessment of Functioning (GAF) represents the DSM-III Global Assessment of Functioning scale score.

Personality Disorders Institute, funded in part by the Borderline Personality Disorders Research Foundation, to assess the efficacy of TFP compared with DBT and SPT for patients with BPD. Dialectical behavior therapy, which has received preliminary empirical support for its effectiveness, was selected as the active comparison treatment. The putative mechanisms of change in these two treatments are conceived in very different ways. Dialectical behavior therapy is hypothesized to operate through the learning of emotion regulation skills in the validating environment of the treatment [80]. Transference-focused psychotherapy is hypothesized to operate through the integration of conflicted, affect-laden conceptions of self and others via the understanding of these working models as they are actualized in the here-and-now relationship with the therapist. Supportive psychotherapy [81, 82] was used in contrast to these two active treatments not only as a control for attention and support but also as a component control for TFP.

In this study, the BPD patients were recruited from New York City and adjacent Westchester County. Ninety-eight percent of the participants were clinically referred by private practitioners, clinics, or family members. Ninety patients (6 men and 84 women) between the ages of 18 and 50 were evaluated using structured clinical interviews and randomized to one of the three treatment cells. Results showed that all three groups had significant improvement in both global and social functioning, and significant decreases in depression and anxiety. Both TFP- and DBT-treated groups, but not the SPT group, showed significant improvement in suicidality, depression, anger, and global functioning. Only the TFP-treated group demonstrated significant improvements in verbal assault, direct assault, and irritability [75] (Table 5.3).

In an earlier report on this sample, we [76] examined changes in attachment organization and RF as putative mechanisms of change. Attachment organization

Table 5.2 Results of TFP vs. TAU study

	TFP (N = 32)		Completers		ITT		TAU (N = 17)		Change Sig	Between-group comparison
	Pre-Tx		Post-Tx		Post-Tx		Pre-Tx	Post-Tx		
ER visits	1.18		0.42		0.59		1.53	1.73	ns	TFP>TAU <0.01
Hospitalizations	1.72		0.46		0.91		2.47	1.93	ns	TFP>TAU <0.01
Days hospitalized	61.1		7.08		25.87		48	53.4	ns	TFP>TAU <0.01
No. of BPD criteria met	7.74		4.41		5.15		7.69	-	-	TFP>TAU -
GAF	45.57		61.0		59.85		44.8	44.66	-	TFP>TAU <0.01

ER visits represent the number of emergency room visits in the previous 12-month period. Hospitalizations represent the total number of hospitalization in the previous 12-month period. No. of BPD criteria was assessed with the SCID-II and provides a dimensional rating of the severity of the disorder. GAF represents the DSM-III Global Assessment of Functioning scale score.

Table 5.3 Results of Clarkin et al.’s [75] randomized clinical trial

Symptom-based measures	Significance of change		
	TFP	DBT	SPT
<i>Primary</i>			
Suicidality	<0.05	<0.05	<i>ns</i>
Anger	<0.05	<0.05	<i>ns</i>
Irritability	<0.05	<i>ns</i>	<i>ns</i>
Verbal assault	<0.05	<i>ns</i>	<i>ns</i>
Direct assault	<0.05	<i>ns</i>	<i>ns</i>
Motor Impulsiveness	<i>ns</i>	<i>ns</i>	<i>ns</i>
Attentional Impulsiveness	<0.05	<i>ns</i>	<i>ns</i>
Non-planning Impulsiveness	<i>ns</i>	<i>ns</i>	<0.05
<i>Secondary</i>			
Anxiety	<0.05	<0.05	<0.05
Depression	<0.05	<0.05	<0.05
GAF	<0.05	<0.05	<0.05
Social adjustment	<0.05	<0.05	<0.05

Suicidality, anger, irritability, verbal and direct assault were assessed with the Overt Aggression Scale – Modified version [109]. Barratt factors are from the Barratt Impulsivity Scale [110]. Anxiety was assessed with the State-Trait Anxiety Inventory [111]. Depression was assessed with the Beck Depression Inventory [112]. GAF represents the DSM-III Global Assessment of Functioning scale score. Social Adjustment was assessed by the Social Adjustment Scale [113].

was assessed using the Adult Attachment Interview (AAI) (George, C., Kaplan, N., & Main, M. (1985). *The Berkeley Adult Attachment Interview*. Unpublished Manuscript, Department of Psychology, University of California, Berkeley) and the RF coding scale (Fonagy, P., Target, M., Steele, H., & Steele, M. (1998). *Reflective Functioning Manual: Version 5.0, for Application to Adult Attachment Interviews*. Unpublished Manuscript, University College London, London). After 12 months of treatment, we found a significant increase in the number of patients classified as secure with respect to attachment state of mind for TFP, but not the other two treatments. Significant changes in narrative coherence and RF were found as a function of treatment, with TFP showing increases in both constructs during the course of treatment. Findings suggest that 1 year of intensive TFP can increase patients’ narrative coherence and RF. Our findings are important because they show that TFP is not only an efficacious treatment for BPD but also works in a theoretically predicted way and thus has implications for conceptualizing the mechanism by which patients with BPD may change. In addition, patients in TFP did better on those variables than those in DBT and SPT. Our findings are especially important given the literature showing that many treatments do not show specific effects on specific, theory-driven mechanisms [83–91] (Table 5.4).

There are a number of methodological strengths of this study such as the use of multiple domains of change to measure outcome, including behavioral, observer-rated, phenomenological, and structural change (i.e., attachment representations, object relations, and mentalization skills). In addition, this

Table 5.4 Results of Levy et al.'s [114] randomized clinical trial

Structural measures	TFP		DBT		SPT		Contrast
	Pre-Tx	Post-Tx	Pre-Tx	Post-Tx	Pre-Tx	Post-Tx	
Reflective functioning	2.86	4.11	3.31	3.38	2.8	2.86	TFP>DBT = SPT
Coherence of narrative	2.93	4.02	3.00	3.25	3.25	3.16	TFP>DBT = SPT

Reflective functioning was assessed based on Fonagy et al.'s [115] manual for scoring RF. Coherence of narrative was assessed based on the Adult Attachment Interview coding system [116].

study included a broad range of BPD patients and not exclusively those with parasuicidality, representing the full spectrum of BPD manifestations. Further, all therapists were experienced in their respective treatment model, had practice cases prior to beginning the study, and were rated for adherence and competence in their delivery of therapy during the study. Adding to the external validity of this research, treatments were delivered in community mental health settings, including outpatient hospitals and private offices of therapists.

In a study in Amsterdam, Arntz and colleagues [92] compared TFP with Young's Schema-Focused Therapy [93] (SFPT), an integrative approach based on cognitive-behavioral or skills-based techniques along with object relations and gestalt approaches. Their study is unique in examining two active treatments over 3 years. Patients benefited from both treatments; however, at first glance, SFPT appeared more efficacious. A number of serious limitations argue against this conclusion.

First, despite randomization, the TFP condition included twice as many recently suicidal patients [76 vs. 38%; there was also a trend ($p = 0.09$) for the TFP condition having more patients with recent self-injury behavior]. Suicidality influences treatment outcome [94].

Second, the differences between the two groups were apparent only in the intent-to-treat (ITT) analyses but not in the completer analyses. A major factor in this difference appears to have been that patients in the TFP condition were significantly more likely to prematurely drop out of their treatment. Although ITT analyses speak to the external validity (e.g., generalizability), completer analyses speak to the issue of sufficient dose and thus the internal validity or integrity of the study. Differences in outcome between completer analyses and ITT suggest loss of validity due to nonrandom dropout. This can negate the control provided by randomization [95]. Completer analyses did not show any statistically significant advantage for SFPT [4, 96].

Third, the findings suggest inadequate implementation of TFP as indicated by lack of adherence by the TFP therapists. The authors report the median adherence level for TFP was 65.6. Given that a score of 60 is considered adherent, about 50% of TFP therapists are nonadherent. In contrast, the

SFPT group had a median score of 85.6 (again with 60 as adherent), suggesting that 50% of the SFT were not just adherent but exceptionally so. Adherence ratings not only were relatively poor for TFP but also appear to be significantly lower than for SFT. Suffice it to say, the authors are reporting a study that compared an exceptionally well delivered treatment with an inadequately delivered one. There should be no surprise that the exceptionally delivered treatment outperformed the poorly delivered treatment, but it is not a fair test and this fact alone may explain the differential outcome between the two treatments. One of the most potent methodological choices that result in allegiance effects is the selection of therapists who differ in skillfulness that favor the allegiance of the researcher [97].

Fourth, treatment integrity includes having experienced treatment cell leaders, choosing experienced and adherent therapists with a proven track record, providing expert supervision, ongoing monitoring of adherence, and having plans for dealing with nonadherence [98]. Each of these issues was problematic in the current study. Supervision was carried out in the form of a peer supervision, known as *interview* [98]. Interview may work well when carried out by exceptionally adherent therapists as was the case for the SFPT. However, such a model would not work well with nonadherent therapists and would be more akin to the blind leading the blind. The authors indicate that treatment integrity was monitored by means of supervision; however, who was doing that monitoring? Yeomans [99] reports the clinical observation that half the therapists were nonadherent, which is consistent with the authors' own independently rated adherence scores. Most disturbing, however, is that Yeomans [99] reports that he informed the study Principal Investigators (PIs) of the nonadherence problem on numerous occasions, including by email and fax and that no action was taken to deal with this problem.

Fifth, therapists and assessors were not blind to ongoing outcome. Partial results were presented prior to study completion [93, 96, 100, 101], creating another possible confound, which could have caused therapist demoralization in the TFP therapists or enhanced motivation in the SFPT therapists [101]. Given these concerns, it would be premature and irresponsible to conclude that TFP is not as efficacious as SFPT is.

Accumulating evidence indicates that TFP may be an effective treatment for BPD. As more data from the RCT is assessed, we will have a better understanding of how the treatment performs under more stringent experimental conditions. Because the RCT better controls for unmeasured variables through randomization, offers controls for attention and support, and compares TFP to an already established, well-delivered, alternative treatment, its outcome will be a strong indicator of the treatment's efficacy and effectiveness. In addition to the assessment of outcome, the RCT has also generated process-outcome studies designed to assess the hypothesized mechanisms of action in TFP that result in the changes seen in these patients [76].

Conclusions

In summary, there are a number of conclusions that can be drawn from the data reviewed in this chapter. Most generally, there are a number of different psychodynamic treatment models that are useful and supported empirically for treating BPD. In addition, there may be other models that share similar principles that are also quite effective but remain untested. We would recommend that proponents of these approaches work toward their examination in RCT designs.

Specifically, we have learned that the following:

1. Experienced psychodynamic psychotherapist can have high levels of drop-out [69, 70, 103].
2. Unmodified classical psychoanalysis is most likely not that helpful for BPD patients (particularly low-level borderlines) [45].
3. Psychoanalysis can be modified to specific types of pathology and can be modified in different ways successfully [28, 29, 75].
4. The principles and goals of psychodynamic treatments for BPD can be articulated and manualized [27, 58].
5. Psychodynamic psychotherapy can be taught to trainees, early career therapists, experienced therapists, and nurses (not just experienced psychoanalyst) [28, 29, 71].
6. We can video or audio tape sessions without disrupting the treatment [71, 75, 89].
7. There is little evidence that purely supportive psychodynamic psychotherapy is effective with BPD patients, although little is known about the extent to which supportive techniques can be or should be integrated in treatments for BPD [75, 76]. Kernberg would argue for less-supportive techniques particularly for low-level BPD patients, whereas Bateman and Fonagy would argue more integration of supportive techniques.
8. Data suggests that therapists can reduce dropout by increasing the structure and explicitly focusing on frame issues with BPD patient; explicit contracts are particularly helpful but may not be necessary if a solid structure and frame can be established and maintained [71, 75, 76].
9. We can perform RCTs of psychodynamic treatments for BPD [29, 75, 76].
10. Some dynamic treatments for BPD can be considered to have beginning empirical support [29, 75, 76], whereas others appear quite promising [28].
11. We can treat unselected and severely disturbed BPD patients not just those with high IQs, high RF, or good quality of object relations [29, 71, 75, 76, 104].
12. Borderline personality disorder patients can show important change in just 1 year [29, 71, 75, 76].
13. We may have broader outcome, longer-lasting outcome, and show changes in personality than those shown in other treatments [29, 71, 75, 76].

14. Long-term treatment is necessary and important in the treatment of BPD in order to see structural changes in personality organization.
15. Supervision is a critical component for the treatment of BPD. All the empirically supported treatments for BPD, not just the psychodynamic ones, have structured ongoing supervision for therapists [29, 71, 75–77, 92]. Additionally, in some studies, differences between groups [92, 105] appear related to difference in the delivery of adequate supervision [98, 106].
16. All treatments for BPD with empirical support are well-structured, devote considerable effort to enhancing compliance (e.g., attention to contracting and frame), have a clear focus, whether that focus is a problem behavior or an aspect of interpersonal relationship patterns; are highly coherent to both therapist and patient; encourage a powerful attachment relationship between therapist and patient, enabling the therapist to adopt a relatively active rather than a passive stance; and are well-integrated with other services available to the patient.

The next step is the identification of the active ingredients or mechanisms of therapeutic action in these treatments [41]. Effectiveness and efficacy aside, the probative importance of these studies for understanding a treatment's actual mechanisms of action is both indirect and limited [107]. Therefore, despite the support for the effectiveness and efficacy of existing treatments for BPD, clinicians and researchers are still confronted with a high degree of uncertainty about the underlying processes of change. The examination of putative mechanisms of change has the potential to answer theoretical questions and to validate models by showing that theoretically specified mechanisms of change are actually related to the treatments' effectiveness. It is very possible that these treatments may work due to unintended mechanisms such as common factors (e.g., expectancies) [108] or a specific technique factor that is essential for good outcome but not necessarily unique to any one treatment [34]. Finally, there may simply be different avenues to effect change in patients with BPD or that different treatments may be more effective with different types of BPD patients.

Additionally, establishment of the underlying mechanisms of the psychopathology in BPD will help to validate clinical approaches. For example, showing through the use of experimental psychopathology paradigms that identity diffusion or deficits in RF underlie the symptoms in BPD would go a long way to establishing the importance of treatment goals emphasized in TFP.

Finally, given the chronicity of BPD, it is crucial to establish the long-term significance of the changes that occur in our treatments. There is already some preliminary evidence that MBT and IP approaches have long-term effectiveness and that this stability of treatment effects may be unique to psychodynamic treatments. If we can continue and accomplish these goals, we may be able to show the unique added value of our approach and avoid going the way of the dodo bird.

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